CASE
excellence through collaboration

Itinerant Services Office

1104 N. Main Street
Lombard, IL 60148-1362

Mindy Long
Administrator

Mary M. Furbush, Ed.D.
Executive Director

630-629-2600, Relay Service 711
Fax 630-629-2601

REFERRAL FOR SERVICES

Student Name_____ Gender: ○ M ○ F Date of Birth_____

Home Phone: (____)_____ Address_____ City_____ Zip_____

Parent(s)/Guardian(s):_____ Work/Cell Phone (____)_____

Resident District: _____ Resident School: _____ Joint Agreement: _____

Attending District: _____ Attending School: _____ School Phone: (____)_____

Attends: ○ AM ○ PM ○ Full Day School Nurse: _____ Nurse Email: _____

Teacher: _____ Teacher Email: _____

Specific concerns that led to this referral: _____

_____

_____

Assessment(s) Requested – check all that apply

☐ Vision Functioning Assessment

Upon receipt of the referral a Functional Vision Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: An Orientation and Mobility Assessment can be requested if the student is currently receiving vision itinerant services or at the same time a request is made for a Vision Functioning Assessment.

☐ Hearing Functioning Assessment

Upon receipt of the referral a Functional Hearing Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: Audiological evaluations are completed through SASED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASED DuPage West Cook. Please contact SASED DuPage West Cook directly at (630) 778-4500.

Please attach this needed documentation:

___ Domain sheet and parent/guardian consent for evaluation
___ Educational screening form completed by teachers___
___ Appropriate medical information (current ocular for vision, audiological for hearing, medically relevant information)
___ Appropriate educational information (i.e. IEP, #504 plan)
___ Appropriate administrative signatures (see below)
___ Class schedule (Jr. High and High School)

Referring Person: _____ Title: _____ Date: _____

District Special Education Administrator: _____ Date: _____

Joint Agreement Director: _____ Date: _____

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Dear Educator:

The Cooperative Association for Special Education (CASE) is pleased to provide you the attached Low Incidence Referral Packet for hearing, and vision itinerant services. All enclosed forms may be duplicated.

Referrals to Low Incidence Itinerant Services, as part of the full and comprehensive case study, for individuals 3 to 22 years, are made by the multi-disciplinary team when the student is being considered for special education services or at any time when an educational disability in the areas of hearing, or vision is suspected. The referral process should follow district procedures in accordance with state and federal statutes and regulations.

Please email or mail a copy of the completed itinerant referral to:

Mindy Long
CASE Itinerant Services
1104 N. Main Street
Lombard, IL 60148
mlong@casedupage.com

When all referral materials are received, the student will be evaluated by a member of the CASE Itinerant Services diagnostic staff in the low incidence domain requested. There will be a diagnostic evaluation charge for each individual evaluation. The school district will receive a copy of the functional report and be billed for the service upon completion of the evaluation.

CASE staff members are available if needed to in-service school districts regarding the use of these forms. If you have any questions regarding the enclosed information or children considered for evaluation, please feel free to contact us.

Respectfully,

Mindy Long
CASE Itinerant Services Administrator

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Please utilize the following pages when making a referral for hearing services

Statement of Services for Children with Hearing Impairment

Hearing itinerant services may be requested to address (but not limited to) the following:

1. Sensorineural loss of hearing in conjunction with described academic difficulties and/or speech and language delays.
2. Audiological monitoring of a progressive hearing impairment in conjunction with an audiologist.
3. Longstanding conductive or fluctuating hearing impairment which has not responded to medical intervention.
4. Longstanding medically documented fluctuating hearing loss.
5. Unilateral hearing impairment which is contributing to a reduction in educational progress in the classroom.
6. A recommendation for monitoring of a hearing impairment by a physician or an audiologist (including ABR results).
7. Preschool or multi-needs children or who are unable to complete a school screening test but who may present a combination of the following symptoms:
    a. Lack of attention or concentration.
    b. Significant speech and language delays, unintelligible speech.
    c. Failure to understand when not facing the speaker.
    d. Inability to comprehend verbal instructions.

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Educational Screening Form for Students with Suspected or Confirmed Hearing Concerns

Student Name: _____ Birthdate: _____ Gender: Male/Female

Primary Language: _____ Grade: ____ School: _____ School Phone: (_____)_____

Teacher: _____ Current related services: _____

Describe any concerns about this student's ability to hear in the classroom:

_____

_____

Do you feel that this child's ability to hear is impacting academic performance? If so, how and how significantly?

_____

_____

Please describe where the student is seated in the classroom:

_____

Does this student use an amplification device? ○YES ○NO (if Yes) Type: _____

	If so, is the amplification device worn consistently?	○YES ○NO
Does this student have difficulty:	listening in the presence of noise?	○YES ○NO
	following verbal directions?	○YES ○NO
	discriminating similar-sounding words?	○YES ○NO
	starting a task without looking at peers?	○YES ○NO
	responding to spoken language?	○YES ○NO

Is this child easily frustrated? ○YES ○NO

Is this student's attention span shorter than his/her peers? ○YES ○NO

Is this student more distractible than others in the classroom? ○YES ○NO

This student's overall academic skills? ○HIGH ○AVERAGE ○LOW

Do you feel this student's achievement reflects his/her potential? _____

For modified/assisted programming students, please describe performance, functioning, and school environment:

_____

_____

Additional comments and information: _____

_____

Signed: _____ Title: _____ Date: _____

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Dear Educator:

The Cooperative Association for Special Education (CASE) is pleased to provide you the attached Low Incidence Referral Packet for hearing, and vision itinerant services. All enclosed forms may be duplicated.

Referrals to Low Incidence Itinerant Services, as part of the full and comprehensive case study, for individuals 3 to 22 years, are made by the multi-disciplinary team when the student is being considered for special education services or at any time when an educational disability in the areas of hearing, or vision is suspected. The referral process should follow district procedures in accordance with state and federal statutes and regulations.

Please email or mail a copy of the completed itinerant referral to:

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1104 N. Main Street
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mlong@casedupage.com

When all referral materials are received, the student will be evaluated by a member of the CASE Itinerant Services diagnostic staff in the low incidence domain requested. There will be a diagnostic evaluation charge for each individual evaluation. The school district will receive a copy of the functional report and be billed for the service upon completion of the evaluation.

CASE staff members are available if needed to in-service school districts regarding the use of these forms. If you have any questions regarding the enclosed information or children considered for evaluation, please feel free to contact us.

Respectfully,

Mindy Long
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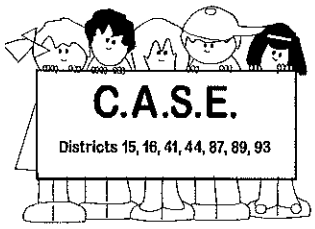
2018



Excellence Together

Please use the following pages when making a referral for vision services

Statement of Services for Children with a Visual Impairment

Vision itinerant services may be requested when, a student exhibits some vision difficulties including, but not be limited to the following:

a) Marked educational difficulties which may be attributed to poor use of vision.

b) Significantly restricted field of vision.

c) Corrected acuity of 20/70, or worse, in the better eye.

d) Marked visual correction (e.g. 20/200 corrected to 20/40).

e) Eye specialist recommends educational assistance.

f) Requires use of low vision aids and/or adapted materials.

g) Prolonged occlusion for amblyopia.

h) Acute, irritated eye diseases requiring prolonged treatment.

i) Post-operative retinal detachment or other post-operative conditions for which the eye specialist recommends intervention. Temporary special services may be required for children with eye diseases which are believed to cause decreased vision temporarily but have a good prognosis.

j) Serious, progressive eye disorders as noted by an eye specialist on the ocular report.

k) Nystagmus (jerky eye movement).

l) Strabismus (turning of one eye).

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REFERRAL FOR SERVICES

Student Name_____ Gender: ○ M ○ F Date of Birth_____

Home Phone: (____)_____ Address_____ City_____ Zip_____

Parent(s)/Guardian(s):_____ Work/Cell Phone (____)_____

Resident District: _____ Resident School: _____ Joint Agreement: _____

Attending District: _____ Attending School: _____ School Phone: (____)_____

Attends: ○ AM ○ PM ○ Full Day School Nurse: _____ Nurse Email: _____

Teacher: _____ Teacher Email: _____

Specific concerns that led to this referral: _____

_____

_____

Assessment(s) Requested – check all that apply

☐ Vision Functioning Assessment

Upon receipt of the referral a Functional Vision Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: An Orientation and Mobility Assessment can be requested if the student is currently receiving vision itinerant services or at the same time a request is made for a Vision Functioning Assessment.

☐ Hearing Functioning Assessment

Upon receipt of the referral a Functional Hearing Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: Audiological evaluations are completed through SASED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASED DuPage West Cook. Please contact SASED DuPage West Cook directly at (630) 778-4500.

Please attach this needed documentation:

___ Domain sheet and parent/guardian consent for evaluation
___ Educational screening form completed by teachers___
___ Appropriate medical information (current ocular for vision, audiological for hearing, medically relevant information)
___ Appropriate educational information (i.e. IEP, #504 plan)
___ Appropriate administrative signatures (see below)
___ Class schedule (Jr. High and High School)

Referring Person: _____ Title: _____ Date: _____

District Special Education Administrator: _____ Date: _____

Joint Agreement Director: _____ Date: _____

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Educational Screening Form for Students with Suspected or Confirmed Vision Problems

Student Name: _____ Birthdate: _____ ○ Male ○ Female

Primary Language: _____ Grade: ____ School: _____ School Phone: (____)_____

Teacher: _____ Current related services: _____

Current special education program: _____ Last Ocular Evaluation Date: _____ (must be within a year)

Describe any concerns about this student's ability to use his/her vision:

_____

_____

Please describe the student's ability to utilize vision in the classroom setting for near vision:

_____

_____

Please describe the student's ability to utilize vision in the classroom setting for distance vision:

_____

_____

List Teacher's questions about the student's use of vision:

_____

_____

Does this student wear glasses?		○ YES	○ NO
Does this student see color?		○ YES	○ NO
In your opinion, does the child need specialized materials?		○ YES	○ NO
This student's overall academic skills?	○ HIGH	○ AVERAGE	○ LOW
Oral and written language skills?	○ HIGH	○ AVERAGE	○ LOW

Do you feel this student's achievement reflects his/her potential? _____

_____

For modified/assisted programming students, please describe performance, functioning, and school environment:

_____

_____

Additional comments and information: _____

_____

Signed: _____ Title: _____ Date: _____

The Cooperative Association for Special Education (CASE) is a 21st century organization that collaborates to provide special education services and support for students in our DuPage County member districts 15, 16, 41, 44, 87, 89, and 93.

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ACCEPTANCE OF EXISTING IEP

*This section should be completed only for students who move into a district with a current IEP and services in the areas of hearing, vision, O & M, or interpreter services. A copy of the current IEP and eligibility must be attached. Please include most recent Ocular and/or Hearing Examination report.

Student Name _____ Birth Date _____ Gender ○ Male ○ Female

Parent(s)/Guardian(s) Name _____ Phone (_____)_____

Address_____

Student's Primary Language _____ Grade_____ Joint Agreement_____

Resident District # _____ Resident School_____ Phone ( )_____

Attending District#_____ Attending School_____ Phone ( )_____

Move-in Date: _____

Special Education program student is currently in _____

Special Education Administrator _____ Phone (____)_____

Teacher _____ Phone (____)_____

Disability(ies)_____

Annual Review Date: _____ Three Year Reevaluation Date _____

Date of last Audiological Evaluation _____ Date of last Ocular Evaluation _____

Minutes per Week / Direct or Consult

- ☐ Vision Itinerant Services _____
- ☐ Hearing Itinerant Services _____
- ☐ Physical Itinerant Consult _____
- ☐ Interpreter _____
- ☐ Orientation and Mobility _____
- ☐ Other _____

Equipment or material used or needed?_____

_____

Authorizations/Signatures:

Referring Person_____Title_____Date_____

District Special Education Administrator _____ Date _____

Joint Agreement Director _____ Date_____

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REQUEST FOR ORIENTATION & MOBILITY SERVICES
(May only be initiated by a CASE vision itinerant teacher)

DATE OF REQUEST _____

PROCEDURES:
Teacher obtains coordinator's approval. Coordinator checks with district and Routes to CASE Itinerant Services offices. **This form should be utilized only for students receiving CASE Vision Itinerant Services. Please attach copy of last IEP and paperwork indicating parent consent.**

Name of Pupil: _____ Date of Birth: _____

Parents: _____ Address: _____

City: _____ Zip: _____

Phone: _____

Resident District: _____ Resident School: _____

Attending District : _____ Attending School: _____

School-based contact information:

Case manager/teacher name: _____

Case manager/teacher Email: _____

Case Manager/teacher Phone: _____

School Nurse _____ Town: _____

Specific reason for request and description of problem: _____

_____

_____

Have there been any pre-referral interventions attempted? YES ☐ NO ☐ If yes, please attach.

Vision Teacher's Signature: _____ Date: _____

District Representative: _____ Date: _____

District Administrator's Signature: _____ Date: _____
(Signature indicates district has been notified and approved this request.)

2018

REFERRAL FORM for HEARING SERVICES

SASED
TEACHING • LEADING • BELIEVING

Email to: Lynne Mennel, lmennel@sased.org
Or fax/mail to: Lynne Mennel
2900 Ogden Avenue, Lisle, IL 60532
Phone #: 630-955-8113 or 630-778-4500
Fax #: 630-778-0196 or 331-903-1544

********THE FOLLOWING DOCUMENTATION IS REQUIRED TO BE SENT WITH THE REFERRAL REQUEST********

_____ Signed Parent Consent and Completed Domain Sheet
_____ Current IEP and
_____ Case Study Evaluation (If applicable)
_____ Medical information:
~ Audiological Report(s)
_____ Administrator Signatures

(PLEASE **CHECK** (√) THE **SERVICE YOU ARE REQUESTING**)
ALL SECTIONS MUST BE COMPLETED.

___***Audiological Evaluation*** *consists of assessment of child's hearing sensitivity, speech reception and discrimination abilities, impedance testing and, if applicable, aided performance.*

___***Functional Listening Assessment*** *consists of an evaluation of a child's listening comprehension of language in the school setting; through observation(s), formalized testing, and consultation with district staff. The evaluation results will assist in recommendations regarding itinerant services, trial use of an assistive listening device, and accommodations related to the student's hearing loss.*

STUDENT: _____ M/F: _____ DATE of BIRTH: _____

ADDRESS: _____
(STREET) (CITY) (ZIP)

PARENT/GUARDIAN NAME: _____ DAYTIME PHONE: _____

EMAIL: _____ CELL PHONE: _____ BEST METHOD TO CONTACT: _____

PARENT/GUARDIAN PREFERRED LANGUAGE: _____ STUDENT PREFERRED LANGUAGE: _____

INTERPRETER NEEDED: YES: _____ NO: _____ DISTRICT OF RESIDENCE: _____
(Name & District #)

STUDENT HOME SCHOOL: _____ ATTENDING SCHOOL: _____

STUDENT CURRENT PLACEMENT: _____ GRADE: _____
(Type of Program: Gen Ed; Self-contained; etc.)

RELATED SERVICES STUDENT RECEIVES: _____

SPECIFIC CONCERNS/QUESTIONS TO BE ADDRESSED BY THIS REFERRAL: (Must be completed.)

_____

_____

_____

_____

TEACHER NAME: _____ PHONE NUMBER: _____ BEST TIME TO CALL: _____

2016

TEACHER REPORT:

Please describe any concerns about this student's ability to hear in the classroom. _____

_____

Do you feel that this child's ability to hear is impacting academic performance? If so, how? _____

_____

Please describe where the child is seated in the classroom. _____

Is there a medical condition that may affect hearing? _____

SO THAT THE EVALUATION CAN ADDRESS SPECIFIC ISSUES, PLEASE ANSWER THE FOLLOWING TO THE GREATEST EXTENT POSSIBLE:

Does the student wear hearing aid(s)?	____ Yes	____ No
If yes, is the hearing aid(s) worn consistently?	____ Yes	____ No
Does the student have difficulty with:		
Listening in the presence of noise?	____ Yes	____ No
Following verbal directions?	____ Yes	____ No
Discriminating similar sounding words?	____ Yes	____ No
Starting a task without watching peers or asking for help?	____ Yes	____ No
Responding to spoken language without visual cues?	____ Yes	____ No
Does this student become easily frustrated?	____ Yes	____ No
Is this student's attention span shorter than peers?	____ Yes	____ No
Is this student more distractible than peers?	____ Yes	____ No

OTHER STUDENT CONCERNS: _____

(i.e.: Medical; Behavioral; Allergies; Anxieties; etc.)

Person Making the Referral: _____ Date: _____

(PLEASE PRINT)

Job Title: _____ Phone Number: _____ Best time to call: _____

Email Address: _____ District: _____

_____ _____

Signature of Building Principal/ Date Signature of Director of Special Education/ Date

If there is any missing documentation, it WILL delay scheduling. **If there are previous evaluations or current therapy reports/IEP for the student, please forward with the referral to facilitate assessment procedures and to prevent duplication.**

Be sure to enclose a signed parent consent form and a completed domain page.

Rev. 11/16/2016

SASED